

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155516		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2011	
NAME OF PROVIDER OR SUPPLIER PARKVIEW MEMORIAL HOSPITAL-CCC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 RANDALLIA DRIVE FORT WAYNE, IN46805			
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Date of Survey: May 4, 5, and 6, 2011</p> <p>Facility Number: 001203 Provider Number: 155516 AIM Number: N/A</p> <p>Survey Team: Julie Wagoner, RN - TC Tim Long, RN Angie Strass, RN</p> <p>Census bed type: SNF: 28 Total: 28</p> <p>Census Payor type: Medicare: 28 Total: 28</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 5-13-11 Cathy Emswiller RN</p>			F0000	This Plan of Correction constitutes our allegation of compliance.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0156 SS=C	<p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p>						

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	<p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p>						

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	<p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on observation and interview the facility failed to ensure Medicare/Medicaid information was visibly posted and available for 28 of 28 residents residing in the facility.</p> <p>finding includes:</p> <p>Observation throughout the East and West halls on 5/6/11 at 1:30 p.m. indicated the facility did not have Medicare/Medicaid contact information posted .</p> <p>Interview with the Director of Nursing (DNS) on 5/6/11 at 1:35 p.m. indicated the information should be posted on the bulletin board. Observation with the DNS indicated the contact information phone numbers were on the two bulletin boards at each end of the hall, but were behind the listings for the state agency's and not visible for access to read.</p>			F0156	<p>1. On 5-11-2011, the Medicare/Medicaid information that was posted behind the state agency listings was moved from behind and placed side-by-side so it was visible on both bulletin boards.2. The correct posting of information was discussed with both activity staff members who maintain the bulletin boards.3. A checklist was developed to include all required postings.4. Quality Monitoring:A. 5East and 5West bulletin board will be monitored each month by activity staff with checklist when monthly calendar is changed to ensure notifications are posted side-by-side for resident visibility.B. Monitoring results will be forwarded to QI Team. Results will be discussed monthly and follow up/new strategy will be initiated if results are not 100%.</p>		05/20/2011

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F0226 SS=C	<p>3.1-4(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility abuse policy and procedure instructed staff to report abuse immediately to the facility Administrator. This potentially affected 28 of 28 residents in the facility.</p> <p>Finding includes:</p> <p>Review of the facility policy and procedure, titled: "Abuse Prohibition", on 05/04/11 at 2:30 P.M., revised and dated on 01/05 and provided by the Director of Nursing, included the following instructions: "... It shall be the policy of the (facility name) that upon the allegation or identification of mistreatment, abuse, neglect, including injuries of unknown source, and/or misappropriation of resident property, the Administrator or designee shall immediately undertake an investigation of the allegation or event...."</p> <p>Interview with the Director of Nursing, on 05/06/11 at 1:30 P.M. indicated herself and/or the Administrator were notified of any allegation of abuse involving the long term care unit of the hospital. She</p>		F0226	<p>Current practice of abuse and neglect notification was evaluated. Current policies for abuse and neglect were reviewed and revised. On 5-23-2011 a memo was sent to all staff clarifying policy and practice revisions for notification of abuse and neglect. Staff will be educated during inservices the week of May 30 of policy and practice changes. Monitoring of the policy changes will occur if an allegation of abuse/neglect is reported. Feedback will be provided to staff member if policy is not followed. Quality Monitor: During yearly Abuse and Neglect education, notification of allegations will be discussed.</p>		06/04/2011	

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	<p>indicated if the hospital house supervisors were the first to be notified of abuse allegations, they knew to contact either herself or the Administrator.</p> <p>No policy was provided regarding what the hospital house supervisors followed if and when they were notified of an allegation of abuse involving a resident of the long term care unit in the facility.</p> <p>3.1-28(a)</p>						

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F0272 SS=D	<p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to thoroughly assess the nutritional fluid needs for 1 of 2 residents with a gastrostomy tube in a sample of 10. (Resident #23)</p> <p>Finding includes:</p> <p>During the initial tour of the facility,</p>			F0272	<p>1. For resident #23, a comprehensive nutritional assessment and plan of care was updated to include fluid, calorie and protein needs. 2. All resident admission assessments were reviewed and updated to include fluid needs. 3. Dietitian has obtained a nutritional assessment form and will be following that format and include that information (including fluid</p>		06/04/2011

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	<p>conducted on 05/04/11 between 10:45 A.M. - 11:30 A.M., RN #10 indicated Resident #23 had recently suffered an Intracranial Bleed and received nothing by mouth. She indicated the resident received tube feeding continuously through a gastrostomy tube at 38 cubic centimeters (cc) /hour (hr).</p> <p>The clinical record for Resident #23 was reviewed on 05/04/11 at 2:55 P.M. The resident had been admitted to the long term care unit of the facility from an acute care floor on 04/06/11. The resident had physician's orders, at the time of his admission to the long term care floor, for the tube feeding, Glucerna to run continuously at 75 cc/hr. There were no specific orders regarding tube feeding flushes or "free fluids. The resident's height was documented to be 5 foot 10 inches and his weight was listed as 202 pounds.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 04/19/11, indicated the resident received nutrition through a gastrostomy tube. The health care plan regarding nutritional needs, for resident #23, initiated prior to the resident's admission to the long term care unit of the facility, and current as of 04/06/11 indicated the following goals: "Adeq (adequate) kcals</p>				<p>needs) in her typed summary note in the electronic record for all admissions. 4. The dietitian will review all residents with tube feedings upon admission to the unit, along with the nutritional assessment, to ensure nutritional and fluid needs are being met.5. Dietitians were educated on the assessment, care plan and free fluid process changes.6. Quality Monitoring:A. Nutrition Services will audit 10 resident medical records per month to ensure the nutritional assessment is being completed accurately, includes assessing fluid needs, and residents with tube feedings are being reviewed upon admission to ensure nutritional and fluid needs are being met.B. Nutrition Services will provide QI monitoring results to CCC Quality Team by the 15th of each month.C. QI monitoring results will be reported, discussed and follow up initiated at monthly CCC QI meetings.D. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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	<p>(kilocalories)/pro(protein) provided/nutr (nutrition), spt (supplement), and monitor nutritional status. There were no specific interventions indicated on how the resident's nutritional needs were to be met. Although the resident was at risk for developing dehydration due to his swallowing impairment and the need for the gastrostomy tube, there was no plan to address the resident's fluid needs.</p> <p>On 04/14/11 there were physician's orders to change the tube feeding from Glucerna running at 75 cc/hr continuously to 2cal HN to run at 38 cc/hr continuously. Again there were no specific orders regarding tube feeding flushes or "free fluids." There was no complete nutritional assessment located on the electronic chart since the resident was admitted to the long term care floor on 04/06/11. The facility's computerized, "electronic" chart contained all nursing and dietary progress notes and assessments, as well as all laboratory results, and other test results.</p> <p>Registered Dietician, employee #4, interviewed on 05/05/11 at 1:15 P.M., indicated the dietician's role in the facility did not generally involve assessing the fluid needs in addition to the caloric needs for tube fed residents, unless specifically requested to do so.</p>						

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	<p>Interview, on 05/06/11 at 10:00 A.M. with the Registered Dietician who normally worked on the long term care unit of the facility, employee #3, indicated the resident was already on the Glucerna tube feeding when he was admitted to the long term care unit so another dietary assessment would not have been completed.</p> <p>A summary note, initially completed March 25, 2011 and revised April 7 and 11 , 2011 calculated the resident's Body Energy Equation, Ideal Body Weight, and Body Mass Index with respect to his height and weight, but there was no mention of the type of tube feeding recommended, the kcal it provided, or any mention of the resident's fluid needs.</p> <p>A nutritional needs note, from the acute care center, dated 04/02/11 indicated the resident had experienced some vomiting while receiving the Glucerna tube feeding and the rate had been decreased with plan to gradually increase the rate until the resident received 75 cc/hr. The kcal (kilocalorie) needs and protein needs were assessed and the resident's blood glucose level ranges were mentioned. Again, there was no mention of the resident's fluid needs or recent laboratory studies other than the blood glucose levels.</p>						

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	Employee #3 indicated the nursing staff were responsible for determining the resident's fluid needs for all residents, even those who received all nutrition and fluids through a gastrostomy tube. 3.1-35(c)(5)						

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F0278 SS=D	<p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 10 residents in a sample of 10 had an accurate Minimum Data Set (MDS) assessment regarding urinary continence.</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 05/04/11 between 10:45 A.M.-11:30 A.M., RN #10 indicated Resident #23 had an indwelling urinary</p>			F0278	<p>1. MDS for resident #23 was corrected and modification was transmitted on 5-20-2011.2. The MDS Coordinator audited three other residents with urinary catheters and the MDS was coded correctly.3. MDS Coordinator has reviewed Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, Section H Bladder and Bowel. MDS Coordinator verbalized understanding of correct urinary catheter coding on the MDS.4.</p>		06/04/2011

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	<p>catheter due to incontinence and urinary retention issues.</p> <p>Resident #23 was observed on 05/04/11 at 2:30 P.M., lying in his bed. An indwelling urinary catheter was noted with the collection bag hanging on the side of the bed.</p> <p>The clinical record for Resident #23 was reviewed on 05/04/11 at 2:55 P.M. The resident was admitted to the long term care unit on 04/06/11. The initial Minimum Data Set (MDS) assessment, completed on 04/19/11 indicated the resident was continent of his bladder.</p> <p>Interview with RN #11, on 05/05/11 at 2:15 P.M. indicated she had been incorrectly coding all residents with a urinary catheter as she was unaware there was a specific code for residents with indwelling urinary catheters. She confirmed the resident had a catheter since his admission to the unit on 04/06/11.</p> <p>3.1-31(g)</p>				<p>Quality Monitoring:A. Form developed to monitor MDS compliance.B. MDS Coordinator will keep list of residents with urinary catheters on form. Medical Record Coordinator will check MDS Section H0300, Urinary Continence for Code "9" prior to transmission.C. Will monitor monthly for 3 months (June, July, August), for 100% compliance. If 100% compliance obtained, will monitor 10 records in (Sept., Oct., Nov.). If 100% obtained will discontinue monitoring. If 100% not obtained, will continue monitoring and QI Team will determine monitoring frequency.</p>		

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure there was a care plan developed regarding potential for dehydration and/or potential for fluid imbalance related to a need for a gastrostomy tube for 1 of 2 residents reviewed with gastrostomy tubes in a sample of 10. (Resident #23)</p> <p>Findings include:</p> <p>During the initial tour of the facility, conducted on 05/04/11 between 10:45 A.M. - 11:30 A.M., RN #10 indicated Resident #23 had recently suffered an Intracranial Bleed and received nothing by mouth. She indicated the resident</p>			F0279	<p>1. For resident #23, a comprehensive nutritional assessment and plan of care was updated to include fluid, calorie and protein needs. 2. All resident care plans were reviewed and updated to include fluid needs. 3. Dietitian has reviewed all care plan goals, problems and interventions available in the electronic care plan system and determined how to implement more complete individualized care plans. As a result, Dietitian is now using additional electronic care plan options when writing plans of care. 4. Dietitians were educated on the assessment, care plan and free fluid process changes. 5. Quality Monitoring: A. Nutrition Services will audit 10 resident</p>		06/04/2011

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	<p>received tube feeding continuously through a gastrostomy tube at 38 cubic centimeters (cc) /hour (hr).</p> <p>The clinical record for Resident #23 was reviewed on 05/04/11 at 2:55 P.M. The resident had been admitted to the long term care unit of the facility from an acute care floor on 04/06/11. The resident had physician's orders, at the time of his admission to the long term care floor, for the tube feeding, Glucerna to run continuously at 75 cc/hr. There were no specific orders regarding tube feeding flushes or "free fluids. .</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 04/19/11, indicated the resident received nutrition through a gastrostomy tube. The health care plan regarding nutritional needs, for resident #23, initiated prior to the resident's admission to the long term care unit of the facility, and current as of 04/06/11 indicated the following goals: "Adeq (adequate) kcals (kilocalories)/pro(protein) provided/nutr (nutrition), spt (supplement), and monitor nutritional status. There were no specific interventions indicated on how the resident's nutritional needs were to be met. Although the resident was at risk for developing dehydration due to his swallowing impairment and the need for</p>				<p>medical records per month to ensure the plan of care includes fluid needs.B. Nutrition Services will provide QI monitoring results to CCC Quality Team by the 15th of each month.C. QI monitoring results will be reported, discussed and follow up initiated at monthly CCC QI meetings.D. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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	<p>the gastrostomy tube, there was no plan to address the resident's fluid needs.</p> <p>On 04/14/11 there were physician's orders to change the tube feeding from Glucerna running at 75 cc/hr continuously to 2cal HN to run at 38 cc/hr continuously. Again there were no specific orders regarding tube feeding flushes or "free fluids." There was no complete nutritional assessment located on the electronic chart since the resident was admitted to the long term care floor on 04/06/11. The facility's computerized, "electronic" chart contained all nursing and dietary progress notes and assessments, as well as all laboratory results, and other test results.</p> <p>Registered Dietician, employee #4, interviewed on 05/05/11 at 2:45 P.M., indicated the dietician's role in the facility did not generally involve assessing the fluid needs in addition to the caloric needs for tube fed residents, unless specifically requested to do so.</p> <p>A summary note, initially completed March 25, 2011 and revised April 7 and 11 , 2011 calculated the resident's Body Energy Equation, Ideal Body Weight, and Body Mass Index with respect to his height and weight, but there was no mention of the type of tube feeding</p>						

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	<p>recommended, the kcal it provided, or any mention of the resident's fluid needs.</p> <p>A nutritional needs note, from the acute care center, dated 04/02/11 indicated the resident had experienced some vomiting while receiving the Glucerna tube feeding and the rate had been decreased with plan to gradually increase the rate until the resident received 75 cc/hr. The kcal (kilocalorie) needs and protein needs were assessed and the resident's blood glucose level ranges were mentioned. Again, there was no mention of the resident's fluid needs or recent laboratory studies other than the blood glucose levels.</p> <p>Employee #3 indicated the nursing staff were responsible for determining the resident's fluid needs for all residents, even those who received all nutrition and fluids through a gastrostomy tube. There was no current health care plan for Resident #23 regarding his fluid needs and/or specific interventions to prevent dehydration.</p> <p>3.1-35(a)</p>						

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F0281 SS=D	<p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 5 nurses observed passing medications followed the facility policy and procedure regarding administering medications through a gastrostomy tube, in that the nurse failed to flush between medications, for 1 of 5 residents observed receiving medications. (Resident #23)</p> <p>Findings include:</p> <p>During observation of a medication pass, conducted on 05/06/11 from 9:00 A.M. - 9:40 A.M., RN #6 had prepared 3 medications for Resident #23. RN #6 was noted to have mixed a packet of polyethylene glycol powder in 220 cc of water. She also crushed a sertraline hydrochloride tablet, placed it in a plastic medication cup and mixed it with 60 cc of water. She had also placed a syringe with 5 ml of liquid Levetiracetam on the overbed table to be administered. Finally, she had obtained a 1/2 cup (approximately 120 cc) of water and set it on the table. After checking the placement of the resident's gastrostomy tube, the nurse placed an open aspiro on the end of the resident's gastrostomy tube and placed approximately 30 cc of the polyethylene</p>			F0281	<p>1. Discussed proper procedure of flushing with plain water between each medication with RN #6. 2. Reviewed Mosby's Nursing Skills "Enteral Feedings via Gastrostomy or Jejunostomy Tube" Quicksheet and "Feeding Tubes Quick Steps". Developed updated procedure. 3. Educator will inservice all staff on medication administration through tubes during inservices the week of May 30. 4. Quality Monitoring: A. Monthly QI tool developed. B. Ten observations each shift will be completed monthly by QI Team member. C. Staff member feedback will be provided regarding compliance immediately after procedure observation. D. QI monitoring results will be reported, discussed and follow up initiated at QI meetings. E. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		06/04/2011

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	<p>glycol/ water mixture into the tube. Next, the nurse put in the 30 cc mixture of sertraline hydrochloride she had prepared. She rinsed the medication cup twice with some of the water from the cup as sediment from the sertraline hydrochloride had remained in the medication cup. Then the nurse immediately placed the syringe full of Levetiracetam into the gastrostomy tube. Finally the nurse finished placing the polyethylene glycol mixture into the tube and after the mixture had been administered, the nurse finished with what was left of the plain water.</p> <p>Review of the policy and procedure the facility utilized, titled: " Mosby ' s nursing skills - enteral feedings via gastrostomy or Jejunostomy tube " indicated the following: " ...5. flush tube with 30 ml of water every 4 to 6 hours around the clock and before and after administering medication via the tube. " The policy did not specify to flush the tube with water between medications.</p> <p>The Director of Nursing indicated, on 05/06/11 at 3:00 P.M., that the tube should have been flushed with water before, between, and after medications.</p> <p>The staff development nurse, RN #5, on 05/06/11 at 3:00 P.M., indicated RN #6</p>						

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	<p>had utilized the polyethylene glycol liquid as a flush since in was mixed in water. She indicated the glass of polyethylene glycol and water mixture along with the 1/2 cup (120 cc) of plain water administered during the medication pass equaled the 400 cc flush ordered to be given every shift for Resident #23.</p> <p>Review of an Internet publication from Cheshire Learning through Nursing, published in 2006, titled "Standards of Practice for the Administration of Medications via (through) a PEG (gastrostomy) Tube" included the following instructions regarding medication administrations: "...It is necessary to flush the PEG (gastrostomy) tube with approximately 10 mls of water between the administration of each medication...."</p> <p>3.1-35(g)(1)</p>						
F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the</p>			F0282	<p>1. Resident #23's feet were placed on pillow with heels positioned off the mattress.2. All</p>		06/04/2011

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	<p>care plan regarding floating heels was followed for 1 of 6 residents reviewed for skin issues in a sample of 10. (Resident #23)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 05/04/11 between 10:30 A.M. - 11:15 A.M., RN #10, upon interview, indicated Resident #23 required extensive staff assistance for transferring and mobility needs, had a specialized mattress to prevent pressure ulcers, had no skin issues, and was fed via a gastrostomy tube.</p> <p>The clinical record for Resident #23 was reviewed on 05/04/11 at 2:55 P.M. The resident was admitted to the long term care unit on 04/06/11. Physician's orders, dated 04/07/11 included orders to "Keep heels up off bed."</p> <p>Resident #23 was observed on 05/04/11 at 11:35 A.M., 05/05/11 at 10:45 A.M., and on 05/05/11 at 2:00 P.M., lying in bed. The resident had green non-slip gripper socks on both feet and his feet and heels were lying directly on the mattress.</p> <p>Review of the current health care plan for Resident #23, initiated on 04/07/11, included interventions to keep the</p>				<p>residents with orders for "heels off bed" were observed and heels were moved to pillows if not already on pillows.3. Staff was verbally reminded to check for heel placement on bed during hourly rounding and assure proper placement.4. Educator will inservice all staff during the week of May 30. Skin integrity care plans (which include heels off bed) will be reviewed along with importance of following care plans. Also will be discussing resident education and teaching residents to assist with keeping heels off the mattress and to call for help when heels are not properly placed. 5. Quality Monitoring:A. Monthly QI tool will be developed. B. Ten observations per shift will be completed monthly by QI Team member.C. Staff member feedback will be provided regarding compliance immediately after procedure observation.D. QI monitoring results will be reported, discussed and follow up initiated at QI meetings.E. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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F0322 SS=G	<p>resident's heels off of the mattress.</p> <p>3.1-35(g)(2)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to thoroughly assess the fluid needs, create a care plan regarding fluid needs, and provide sufficient fluids, for 1 of 2 residents requiring the use of a gastrostomy tube in a sample of 10. This failure resulted in the resident becoming mildly clinically dehydrated until additional fluids were given. (Resident #23)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 05/04/11 between 10:45 A.M. - 11:30 A.M., RN #10 indicated upon interview, Resident #23 had recently suffered an Intracranial Bleed and received nothing by mouth. She indicated the resident received tube feeding</p>		F0322	<p>1. For resident #23, a comprehensive nutritional assessment and plan of care was updated to include fluid, calorie and protein needs. 2. Nurse caring for resident on 4-26-2011 was counseled on notifying physician of lab results, documentation and follow through. 3. All resident nutritional status for fluids were reviewed and updated to include fluid needs. 4. Dietitian has reviewed all care plan goals, problems and interventions available in the electronic care plan system and determined how to implement more complete individualized care plans including fluid needs. As a result, dietitian is now using additional electronic care plan options when writing plans of care. 5. The dietitian will review all residents with tube feedings upon admission to the unit, along</p>		06/04/2011	

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	<p>continuously through a gastrostomy tube at 38 cc(cubic centimeter)/hr(hour).</p> <p>The clinical record for Resident #23 was reviewed on 05/04/11 at 2:55 P.M. The resident had been admitted to the long term care unit of the facility from an acute care floor on 04/06/11. The resident had physician's orders, at the time of his admission to the long term care floor, for the tube feeding, Glucerna to run continuously at 75 cc/hr. There were no specific orders regarding tube feeding flushes or "free fluids. The resident's height was documented to be 5 foot 10 inches and his weight was listed as 202 pounds.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 04/19/11, indicated the resident received nutrition through a gastrostomy tube. The health care plan regarding nutritional needs, for resident #23, initiated prior to the resident's admission to the long term care unit of the facility, and current as of 04/06/11 indicated the following goals: "Adeq (adequate) kcal(kilocalories)/pro(protein) provided/nutr(nutrition), spt (supplement), and monitor nutritional status. There were no specific interventions indicated on how the resident's nutritional needs were to be met. Although the resident</p>				<p>with the nutritional assessment, to ensure nutritional and fluid needs are being met.6. Policy, Dietary Services was reviewed and revised.7. Dietitians were educated on the assessment, care plan and free fluid process changes.8. Educator will inservice all staff notifying physician of lab work and tube feeding fluids during inservices the week of May 30. 9. Quality Monitoring:A. CCC Monthly QI tool will be developed for lab work reporting. B. A CCC QI Team member will audit 10 resident charts per month to verify physician notification of lab results. C. Audit results will be shared during monthly QI meetings.D. Nutrition Services will audit 10 resident medical records per month to ensure fluid needs were assessed and the plan of care includes fluid needs.E. Nutrition Services will provide QI monitoring results to CCC Quality Team by the 15th of each month.F. QI monitoring results will be reported, discussed and follow up initiated at monthly QI meetings.G. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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	<p>was at risk for developing dehydration due to his swallowing impairment and the need for the gastrostomy tube, there was no plan to address the resident's fluid needs.</p> <p>On 04/14/11 there were physician's orders to change the tube feeding from Glucerna running at 75 cc/hr continuously to 2cal HN to run at 38 cc/hr continuously. Again there were no specific orders regarding tube feeding flushes or "free fluids." There was no complete nutritional assessment located on the electronic chart since the resident was admitted to the long term care floor on 04/06/11.</p> <p>Review of Resident #23's blood BUN (blood urea nitrogen) level and Creatinine levels, indicated on 04/26/11 the resident's levels were both elevated to a Bun of 45 and Creatinine level of 1.4. Normal levels for a BUN range from 7 - 18 mg/dL and the normal Creatinine levels range from .8 - 1.3 mg/dL. According to Lippincot Manual of Nursing, 7th Edition, copyright 2001, under Table 20 -2 regarding Complication of Electrolyte Imbalance - Causing Dehydration, nursing measures to monitor included, Blood Urea Nitrogen levels. A physician's order was received on 05/03/11 for 400 ml of free fluid three times a day to be given. On 05/04/11, a</p>						

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	<p>subsequent BUN and Creatinine level indicated the levels had dropped and were now 28 and 1.1 respectively.</p> <p>Interview with Registered Dietician, employee #4, who was covering for the dietician normally assigned to the long term care floor, on 05/05/11 at 1:15 P.M. indicated she had spoken with the dietician who covered the long term care floor and discovered the resident was evidently having poor tolerance to the Glucerna tube feeding as evidenced by diarrhea and residual so when meeting with the interdisciplinary team, she, the dietician normally assigned to the long term care unit, verbally recommended the resident be changed to the 2cal HN tube feeding. RD #4 indicated the nursing staff do not always acknowledge the dietician's role in change or recommendation in the written physician's order. The RD also indicated the dietician's role in the facility did not generally involve assessing the fluid needs in addition to the caloric needs for tube fed residents, unless specifically requested to do so. She indicated the Glucerna tube feeding had an osmolity of 85 percent which meant 85 percent of the total feeding counted as free fluids, whereas the 2cal HN was a more concentrated formula so only 70 percent of the total liquid could count as free</p>						

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	<p>fluid. When asked to quickly determine the free fluid needs, in addition to fluids obtained in each respective tube feed, she indicated the resident would have required an additional 405 cc of free fluid in a 24 hour period while receiving the Glucerna tube feeding, to meet his required fluid needs. She indicated the resident's free fluid needs would have increased to an additional 1,788 cc of free fluids in a 24 hour period when the tube feeding was changed to the 2calHN.</p> <p>According to the Indiana Diet Manual guidelines, an adult male, without any renal issues, required between 2754 - 3214 ml of free fluid per day. The presence of diarrhea or elevated temperature would place the resident's fluid needs towards the higher end of the recommendation. Thus, with respect for the differing rates and osmolality of the Glucerna versus the 2calHN, the resident would have required 1,314 additional milliliters of free fluid to equal 2,754 ml of free fluid for the Glucerna tube feedings, and 2,116 ml of additional free fluid to equal 2,754 ml of free fluid for the 2cal HN tube feeding.</p> <p>Interview with the Director of Nursing, on 05/05/11 at 3:30 P.M., indicated the facility had a standard protocol regarding flushing a continuous gastrostomy tube.</p>						

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	<p>She indicated she thought the standard was 200 cc of water flushes per shift. Review of the facility policy and procedure, undated and titled, "Mosby's Nursing Skills Enteral Feedings via Gastrostomy or Jejunostomy Tube", provided by RN #12 indicated as current, included instructions to "flush the tube with 30 ml of water every 4 to 6 hours around- the-clock and before and after administering medication via the tube."</p> <p>Review of the electronic charting regarding intake records from 04/07/11 - 05/04/11 indicated total free fluid recorded varied greatly from 120 cc of free fluid in a 24 hour period to 1, 240 cc of free fluid. However, the average free fluids given in a 24 hour period was 653 cc of free fluid.</p> <p>Interview, on 05/06/11 at 10:00 A.M. with the Registered Dietician who normally worked on the long term care unit of the facility, employee #3, indicated the resident was already on the Glucerna tube feeding when he was admitted to the long term care unit so another dietary assessment would not have been completed.</p> <p>A summary note, initially completed March 25, 2011 and revised April 7 and 11, 2011 calculated the resident's Body</p>						

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	<p>Energy Equation, Ideal Body Weight, and Body Mass Index with respect to his height and weight, but there was no mention of the type of tube feeding recommended or any mention of the resident's fluid needs.</p> <p>A nutritional needs note, from the acute care center, dated 04/02/11 indicated the resident had experienced some vomiting while receiving the Glucerna tube feeding and the rate had been decreased with plan to gradually increase the rate until the resident received 75 cc/hr. The kcal (kilocalorie) needs and protein needs were assessed and the resident's blood glucose level ranges were mentioned. Again, there was no mention of the resident's fluid needs or recent laboratory studies other than the blood glucose levels.</p> <p>Employee #3, on 05/06/11 at 10:00 A.M., indicated the nursing staff were responsible for determining the resident's fluid needs for all residents, even those who received all nutrition and fluids via a gastrostomy tube. She also indicated she did not recommend the increased free fluid flushes ordered on 05/03/11.</p> <p>3.1-44(a)(2)</p>						

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F0323 SS=D	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation and interview the facility failed to store 3 oxygen cylinders in a safe environment, and failed to ensure a sanitizing agent was locked in a safe place. This had the potential to effect 28 of 28 residents.</p> <p>Findings includes:</p> <p>1. During the environmental tour on 5/4/11 at 2:15 p.m. three oxygen cylinders on wheels were observed on the East hall in a storage room. The room was observed to be carpeted and not ventilated.</p> <p>Interview with the Director of Nursing on 5/5/11 at 3:00 p.m. indicated the therapy staff had been storing the portable oxygen tanks in the hall storage room but were suppose to be storing them in the therapy room which had ventilation and no</p>			F0323	<p>1. On 5-4-11, three oxygen cylinders were removed from the storage room and the Sanimaster was removed from the shower room.</p> <p>2. On 5-4-11, the entire unit was checked for oxygen cylinders and unlocked Sanimaster bottles and none were found.</p> <p>3. On 5-5-11, met with Facilities Manager and plans were made to install locked cabinet for the Sanimaster in the shower room.</p> <p>4. On 5-18-11, a locked cabinet was installed in the shower room.</p> <p>5. On 5-19-11, staff was notified by email of installation of locked cabinet, code to unlock cabinet and to begin using.</p> <p>6. Procedure "Cleaning Responsibilities" was revised to include the locking of Sanimaster in the cabinet.</p> <p>7. Respiratory Therapy reviewed/revised oxygen portable cylinder storage policy.</p>		06/04/2011

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	<p>carpeting.</p> <p>2. During the environmental tour on 5/4/11 at 2:15 p.m. observation of the East Hall shower room indicated a bottle of "Sanimaster 4 One Step Disinfectant" with approximately 350 milliliters of liquid, was in an unlocked cabinet.</p> <p>On 5/6/11 at 8:30 a.m. review of the Material Safety Data Sheet for the "Sanimaster 4" indicated the solution may cause eye and skin irritation.</p> <p>During the daily exit on 5/4/11 at 3:15 p.m., RN #12 indicated the sanitizer should be kept in a locked environment.</p> <p>On 5/6/11 at 1:35 p.m. review of the facility policy and procedure "Cleaning Responsibilities" dated 4/94 indicated "cleaning supplies are kept locked in the soiled utility room in the locked cupboard."</p> <p>3.1-45(a)(1)</p>				<p>8. Educator will inservice all staff on oxygen cylinder storage and locking of Sanimaster during inservices the week of May 30.</p> <p>9. Quality Monitoring:</p> <p>A. Monthly QI tool will be developed.</p> <p>B. Ten observations will be completed monthly by QI Team member.</p> <p>C. Staff member feedback will be provided regarding compliance immediately after procedure observation.</p> <p>D. QI monitoring results will be reported, discussed and follow up initiated at QI meetings.</p> <p>E. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 10 residents reviewed for medications in a sample of 10, were free from duplicate drug therapy. (Resident #27)</p> <p>Finding includes:</p> <p>During observation of a medication pass, conducted on 05/05/11 at 9:00 A.M., LPN #9 was noted to administer both Ferrous Sulfate 325 mg one tablet and Poly - Iron 150 mg one tablet along with his other</p>			F0329	<p>1. LPN #9 was counseled on the practice of questioning duplicate med orders prior to giving both medications. 2. Pharmacist (employee #13) contacted physician for Resident 27. Ferrous sulfate was discontinued. 3. Med Safety Pharmacist re-entered orders in a test environment to analyze the alert produced by the pharmacy information system. The combination of Ferrous Sulfate and Niferex triggered a therapeutic duplication alert but did not trigger a drug-drug interaction. This is aligned with</p>		06/04/2011

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	<p>morning medications. The nurse was queried as to the necessity of administering two iron replacement medications for the resident and she acknowledged the duplicate medications in the same category, indicated she did not know the reason they were ordered to be given at the same time, but gave the medications anyway.</p> <p>The clinical record for Resident # 27 was reviewed on 05/05/11 at 2:10 P.M. The resident was admitted to the long term care unit on 04/25/11. The admission order included orders for the iron replacement medication, Feosol 325 mg three times a day. The resident also had post operative orthopedic orders for a different iron supplement, Niferex 150 mg twice a day for one month to be given.</p> <p>The unit manager, RN #10 was questioned, on 05/05/11 at 2:30 P.M. regarding the duplicate iron medications for Resident #27 and she indicated the orthopedic patients admitted to the facility after surgery routinely had duplicate iron medications ordered.</p> <p>However, interview with a facility pharmacist, Employee #13, on 05/06/11 at 1:10 P.M. indicated the medications had both been ordered by different physicians but had been dispensed and administered</p>				<p>standard pharmacy references. Drug-Drug interactions are reported with levels 1, 2 and 3. Therapeutic duplications are not reported with levels. All therapeutic duplications must be evaluated by a pharmacist, however, not all represent unnecessary medications. For example, Morphine may be ordered as a scheduled med and prn med for break through pain. 4. Event was reviewed with pharmacist that entered both Iron orders. He understands his responsibility in this situation. 5. Med Safety Pharmacist has reviewed all current residents for duplicate iron orders and none were found. 6. Pharmacy management team reviewed policy/procedure for identifying duplicate therapy and notifying physicians of irregularities. The team determined no changes are needed. 7. CCC Educator will inservice all staff on the process of new order review and monitoring for duplicate medication ordering during inservices the week of May 30. 8. Pharmacists serving the CCC will receive one-on-one education/reinforcement of current policy. The pharmacy educator will ensure this activity is completed and documented. 9. Quality Monitoring: A. CCC QI will develop a monitoring form. B. Ten admission charts will be reviewed monthly for duplicate med orders. C. Pharmacy will</p>		

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	<p>in error. She indicated the pharmacy computer system had alerted at a "level 3" interaction as duplicate iron supplement can cause gastrointestinal distress such as loose stools, but the pharmacist reviewing the medications had "bypassed" the alert and sent both ordered medications. She indicated the pharmacy computer system sent several "level 3" alerts and they were routinely "bypassed" by the pharmacist without alerting the nursing staff or the physician of the discrepancy. She indicated if the alert level had been at a "level 2 or 1" then the pharmacist would have clarified the medication orders before dispensing the medications.</p> <p>Interview with Resident #27, on 05/06/11 at 2:00 P.M. indicated he only had a few days of loose stools after his knee surgery. He attributed the problem to a routine order for a stool softener that nursing staff initially convinced him to take. He indicated since the stool softeners had been stopped, he was not having any current nausea or diarrhea or bowel issues. He indicated he did have a decreased appetite even though the facility food was good.</p> <p>3.1-48(a)(1)</p>				<p>forward QI monitoring data to CCC Quality Team by the 15th of each month. D. QI monitoring results will be reported, discussed, and follow up initiated. E. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview the facility failed to ensure proper food storage, improper sanitation of dishes, utensils and pans and food preparation for 26 residents who ate food orally of 28 residents.</p> <p>Findings include:</p> <p>Observation of the kitchen on 5/4/11 from 9:45 A.M. to 10:45 A.M. indicated 2 packages of beef flank steaks in the meat cooler at 36 degrees Fahrenheit, were on</p>			F0371	<p>1. Beef flank steaks and boxes of bacon were discarded.2. All items in the meat cooler were checked for dates.3. Employee #17 was counseled on the proper procedure for hand washing, glove removal, touching microwave and touching food when serving meals.4. On 5-6-11 EcoLabs arrived and adjusted the amount of drying solution dispensed.5. New rinse agent produce (FastDry) was implemented to allow faster drying time.6. Inservices were conducted for dietary staff by</p>		06/04/2011

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	<p>shelves out of their boxes and were undated as to when they were removed from their packing boxes.</p> <p>In the meat cooler, at 36 degrees Fahrenheit, 6 boxes of bacon were on shelves had a packed date of 3/30/11. The boxes had a label which indicated to keep frozen. No other dates were on the box indicating when the boxes of bacon were delivered to the facility and placed in the meat cooler.</p> <p>An interview with the chef on 5/4/11 at 10:30 A.M. indicated the boxes of bacon come right off the delivery truck to the meat locker. The boxes usually have a delivery date on them.</p> <p>Observation of the dishwashing machine on 5/4/11 at 10:40 A.M. indicated 25 or 25 test serving trays came out wet. The dietary employee putting clean dishes away was noted to be stacking the visibly wet trays on top of one another in a stack without allowing the wet trays to air dry.</p> <p>An interview with the dietary manager on 5/4/11 at 10:45 A.M. indicated the company which maintains the dishwasher would be contacted why the dishes were not drying properly. The dietary manager indicated the facility's dish machine was</p>				<p>supervisor and included dating of food in the meat cooler, dish machine operation and drying of the dishes, and hand washing/food service procedures when serving meals. 7. Quality Monitoring: A. Nutrition Services will provide QI monitoring results to CCC Quality Team by the 15th of each month. B. QI monitoring results will be discussed and follow up initiated at QI meetings. C. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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	<p>equipped with a "blower" system which was to dry the dishes before they came out of the dishmachine.</p> <p>An interview with the dietary consultant on 5/6/11 at 1:45 P.M. indicated the company which maintains the dishwasher was there on 5/6/11 and fixed the dishwasher by adjusted the amount of drying solution.</p> <p>An observation for food preparation on 5/4/11 from 11:40 A.M. to 12:30 P.M. for 26 of the 28 residents on the unit indicated on 6 occasions the, dietary employee #17, touched the microwave handle then directly touched food and/or top plate surfaces where food would touch. Employee #17 opened the microwave with his gloved right hand then used his right hand to removed submarine buns out of a bag twice and touched the inner top portion of 2 plates with his right hand. He then washed hands, put on new gloves, opened the microwave with his left hand and used his left hand to get out 2 submarine buns, then opened the microwave with his right hand, got another submarine bun out of the package with his left hand. Employee #17 removed his gloves, washed his hands and used both hands opening the microwave and touched the inner top portion of a plate and removed a</p>						

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F0428 SS=D	<p>submarine bun from the package. He opened the microwave again and removed a submarine bun with his right hand. He opened the microwave with his right hand and removed a submarine bun with his right hand.</p> <p>3.1-21(i)(3)</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility pharmacy failed to ensure the pharmacist reported a duplicate iron replacement medication to the nursing staff and/or the physician for 1 of 10 residents reviewed for medications in a sample of 10. (Resident #27)</p> <p>Finding includes:</p> <p>During observation of a medication pass, conducted on 05/05/11 at 9:00 A.M., LPN #9 was noted to administer both Ferrous Sulfate 325 mg one tablet and Poly - Iron 150 mg one tablet along with his other</p>			F0428	<p>1. Pharmacist (employee #13) contacted physician for Resident 27. Ferrous sulfate was discontinued.</p> <p>2. Event was reviewed with pharmacist that entered both Iron orders. He verbalizes understanding of his responsibility in this situation.</p> <p>3. Pharmacy management team reviewed policy/procedure for identifying duplicate therapy and notifying physicians of irregularities. The team determined no policy/procedure changes are needed.</p> <p>4. Pharmacists serving the CCC will receive one-on-one education and reinforcement of</p>		06/04/2011

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	<p>morning medications. The nurse was queried as to the necessity of administering two iron replacement medications at the same time for the resident and she acknowledged the duplicate medications in the same category, indicated she did not know the reason they were ordered to be given at the same time, but gave the medications anyway.</p> <p>The clinical record for Resident # 27 was reviewed on 05/05/11 at 2:10 P.M. The resident was admitted to the long term care unit on 04/25/11. The admission order included orders for the iron replacement medication, Feosol 325 mg three times a day. The resident also had post operative orthopedic orders for a different iron supplement, Niferex 150 mg twice a day for one month to be given.</p> <p>The unit manager, RN #10 was questioned, on 05/05/11 at 2:30 P.M. regarding the duplicate iron medications for Resident #27 and she indicated the orthopedic patients admitted to the facility after surgery routinely had duplicate iron medications ordered.</p> <p>However, interview with a facility pharmacist, Employee #13, on 05/06/11 at 1:10 P.M. indicated the medications had both been ordered by different physicians</p>				<p>current policy. The pharmacy educator will ensure this activity is completed and documented.</p> <p>5. Quality Monitoring: A. Pharmacy will forward QI monitoring data to the CCC Quality Team by the 15th of the month. B. QI monitoring results will be discussed and follow up initiated at QI meetings. C. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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	<p>but had been dispensed and administered in error. She indicated the pharmacy computer system had alerted at a "level 3" interaction as duplicate iron supplement can cause gastrointestinal distress such as loose stools, but the pharmacist reviewing the medications had "bypassed" the alert and sent both ordered medications. She indicated the pharmacy computer system sent several "level 3" alerts and they were routinely "bypassed" by the pharmacist without alerting the nursing staff or the physician of the discrepancy. She indicated if the alert level had been at a "level 2 or 1" then the pharmacist would have clarified the medication orders before dispensing the medications.</p> <p>Interview with Resident #27, on 05/06/11 at 2:00 P.M. indicated he only had a few days of loose stools after his knee surgery. He attributed the problem to a routine order for a stool softener that nursing staff initially convinced him to take. He indicated since the stool softeners had been stopped, he was not having any current nausea or diarrhea or bowel issues. He indicated he did have a decreased appetite even though the facility food was good.</p> <p>3.1-25(h)</p>						

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F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure 3 of</p>			F0441	1. LPN's #8, #9 and RN #11 were verbally counseled in the proper procedure for sanitation of the		06/04/2011

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	<p>3 licensed nurses (LPN #8, 9, and RN #11) observed obtaining blood glucose levels followed instructions for proper sanitation of the glucometers. In addition, the facility failed to ensure 1 of 6 nursing staff (Employee #19) observed providing care followed standard handwashing and gloving procedures. The facility also failed to ensure urinals were placed in appropriate places. These deficient practices affected 7 of 10 residents reviewed for infection control in a sample of 10. (20, 21, 22, 25, 26, 27, and 14) These deficient practices potentially affected all 28 residents in the facility.</p> <p>Findings include:</p> <p>1. During observation of blood glucose level measurements, on 05/04/11 at 11:30 A.M., after obtaining the blood sugar level for Resident #20, LPN #8 wiped the outside of the glucometer machine with foam hand sanitizer, walked out of the resident's room, and then proceeded to wipe the outside of the glucometer machine with a germicidal disposable wipe. LPN #8 only wiped the glucometer machine for a few seconds and then proceeded to gather his supplies for the next blood glucose measurement for another resident.</p> <p>2. During observation of blood glucose</p>				<p>glucometers. 2. Director of Rehab Services was notified of therapy staff member's isolation procedure deficiency.3. PDI (Professional Disposables International, Inc. supplier of Sani Wipes) provided written clarification for contact time.4. Educator will inservice all staff on sanitation of glucometers, urinal placement when patient not using, hand washing prior to putting on gloves, sanitizing over-bed tables, and ambulating the patient in isolation during inservices the week of May 30. 5. Policy/Procedure entitled "Transmission Based Precautions" was reviewed and no changes necessary. 6. Quality Monitoring:A. Monthly QI monitoring tool was developed to monitor infection control practices such as hand washing, glove removal, sanitizing over-bed tables, urinal storage, and sanitation of glucometers. B. Ten staff observations per shift will be completed monthly by QI Team member. QI Member will observe hand washing, glove removal, santizing over-bed tables, urinal storage, and sanitation of glucometers. C. Staff member feedback will be provided regarding compliance immediately after procedure observation with the staff member observed, as well as, reporting results monthly at QI Meeting.D. QI monitoring results will be reported, discussed and follow up</p>		

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	<p>level measurements, on 5/6/11 at 11:00 A.M., RN #11 wiped the outside of the glucometer with germacidal wipes for approximately 5 seconds, let air dry for 2 minutes, then checked resident #33's blood sugar. RN #11 then wiped the outside of the glucometer with germacidal wipes for approximately 5 seconds, let air dry for 2 minutes and checked resident #34's blood sugar. RN #11 then wiped the outside of the glucometer with germacidal wipes for approximately 5 seconds, let air dry for 2 minutes and checked resident #35's blood sugar.</p> <p>3. During observation of the blood glucose level measurements, on 05/05/11 at 11:40 A.M., LPN #9 was noted to obtain supplies from a cupboard in the hallway, walked into Resident #20's room, put on gloves, scanned the resident's arm band, and proceeded to obtain the resident's blood glucose level. The nurse did not wash her hands prior to putting on her gloves to complete the procedure. After she had obtained Resident #20's blood glucose level, she removed her gloves, used hand sanitizer to wash her hands, then wiped the blood glucometer machine with a germicidal disposable wipe. The nurse then immediately gathered her supplies, put on disposable gloves, and went into Resident #24's room. LPN #9 knocked on the bathroom</p>				<p>initiated at monthly QI meetings. E. QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached, not less than six months of observations.</p>		

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	<p>door with her gloved hands, opened the bathroom door, then when she realized Resident #24 was either in the restroom or not in his room, she exited the resident's room with the disposable gloves still on her hands. She then touched her portable computer screen and papers with her gloved hands, then went into Resident #27's room to perform a blood glucose test. After obtaining Resident #27's blood glucose level, LPN #9 again wiped off the blood glucometer machine with the germicidal disposable wipe.</p> <p>Review of the usage instructions, located on the back of the germicidal wipes containers, indicated the following instructions: " Cleaning procedure: All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil...Contact time: Use second germicidal wipe to thoroughly wet surface. Allow to remain wet two (2) minutes, let air dry "</p> <p>Interview with RN #7, the nurse in charge of Infection Control education and surveillance on the long term care unit, on 05/05/11 at 2:40 P.M. indicated the facility policy and procedure for sanitizing glucometer machines indicated staff were</p>						

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	<p>to utilize the germicidal wipe at the bedside before exiting the resident 's room on the glucometer machine. The staff were to make sure all outside surfaces of the glucometer machine were wiped and then the machine was to air dry. There was no policy and procedure in place to ensure the surface of the glucometer machine remained wet for 2 minutes to allow the germicide to kill all infectious organisms.</p> <p>Review of the facility s policy and procedure regarding hand hygiene and glove use indicated hand hygiene was to be performed before clean/aseptic procedures....gloves are to be used to prevent contamination of health care workers hands when: ...c. handling or touching visibly or potentially contaminated patient care equipment and environmental surfaces.... "</p> <p>4. During the initial tour of the facility, conducted on 05/04/11 between 10:45 A.M. - 11:30 A.M., RN #10 indicated 4 of the 9 residents on the west side of the long term care unit were in contact isolation. The residents identified, by RN #10 on the initial tour conducted on 05/04/11 between 10:45 A.M. - 11:30 A.M., as being in " contact isolation " were Resident #21, 22, 25, and 26. RN #10</p>						

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	<p>indicated Residents #21 and 22 had MRSA (Methicillin Resistant Staph Aurous) infections and had orthopedic hardware removed due to the infections, Resident #26 had a history of MRSA infections in a previous acute care hospitalization, and Resident #25 had a VRE (Vancomycin Resistant E-coli) infection in her urine. She indicated the facility's policy and procedure for contact isolation required staff to wear gloves and gowns when entering the resident's room. She indicated the protective measures were the same for all residents in contact isolation regardless of the location and manner of their infections.</p> <p>On 05/05/11 at 9:45 A.M., a female staff member, later identified, by LPN #9, as "therapy" was noted in Resident #21's room. The therapy staff member, Employee #19, was not wearing any gloves or gown at the time of the observation and was noted to have her arm around Resident #21 while she assisted her to stand and position her walker. LPN #9 was questioned regarding the isolation status of Resident #21 and confirmed the resident was still to be in contact isolation due to her MRSA (methicillin resistant staph aureus) infection. By the time LPN #9 had noted the situation, the staff member assisting Resident #21 had put on gloves, and put</p>						

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	<p>gloves on Resident #21 and was assisting her to exit her room to go to the therapy room. LPN #9 indicated Resident #21 could exit her room as long as she had clean clothes on and wore gloves.</p> <p>Interview with RN #7, the nurse in charge of Infection Control measures and surveillance on the long term care unit, on 05/05/11 at 2:40 P.M. indicated the residents in "contact isolation" were only required to wear gloves and clean clothing when exiting their rooms for therapy. She indicated the therapy staff would not wear a gown when working with the residents in the therapy room but should wear a gown and gloves if working with the resident's in their room. She stated the facility's policy was this way because "therapy" was so important to the resident's stay while in the long term care unit of the facility. She indicated families and visitors did not have to wear any protective equipment but were instructed to use hand hygiene. She stated only those visitors who might go room to room were required to wear protective equipment.</p> <p>Review of the facility's policy and procedure, dated as reviewed on 06/10, titled, PPE (Patient Protective Equipment) worn in the TBP (transmission based precautions) room included the following:</p>						

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	<p>"...2. Contact Precautions a. gown b. gloves c. other PPE as necessitated per standard precautions..."</p> <p>Review of the facility's policy and procedure, titled, "Transporting the patient in TBP (transmission based precautions), dated as reviewed and current as of 06/10, indicated the following: "...2. Contact Precautions...b. The patient dons a clean gown or clothing c. The patient performs HH (hand hygiene) d. The patient is transferred within the patient room to the cart/wheelchair while the HCW's (health care worker's) wear PPE. (Personal Protective Equipment), e. The HCW pushes the cart/wheelchair to the end of the room. f. The HCW cleans handles or rails of the cart/wheelchair g. The HCW removes PPE at the exit of the room, discarding within the room h. The HCW performs HH i. The HCW will not wear PPE after exiting the patient room...."</p> <p>3. During observation of a medication pass, conducted on 05/05/11 at 9:00 A.M., Resident #27 's partially full urinal was observed hanging on the resident' s Intravenous pole. The urinal was observed to remain in the same position for over 1 hour.</p> <p>Interview with the resident, on 05/06/11 at 2:30 P.M. indicated he usually placed the</p>						

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	<p>used urinal on the Intravenous pole because his friend " had a fit " when he placed the used urinal on his overbed table. He indicated he utilized the urinal several times a day.</p> <p>5. Interview with resident #14 on 5/5/11 at 9:30 a.m. indicated staff put his urinal on his bedside table after they would empty the urinal. Resident #14 indicated he placed his urinal on the bed rail.</p> <p>On 5/5/11 at 2:05 p.m. nurse #20 entered the room to do a sterile dressing for resident #14. She removed the resident's urinal, which was on the overbed table, and proceeded to set up her sterile field for the dressing change without sanitizing the overbed table.</p> <p>3.1-18(b) 3.1-18(b)(1)(A) 3.1-18(b)(2)</p>						

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F0520 SS=F	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview the facility failed to ensure a physician attended quality assurance meetings at least quarterly and failed to identify and correct deficient infection control procedures. This potentially affected 28 of 28 residents on the long term care unit.</p> <p>Findings include:</p> <p>During review of the quality assurance committee minutes for the months of September, October and December of 2010 and March and April of 2011 it was</p>			F0520	<p>1. On 5-11-2011, Director of Nursing discussed QI meeting schedule with Medical Director and meeting attendance.2. Medical Director was notified of QI meeting to be held on 5-25-2011, and he placed it on his schedule. 3. DON will remind Medical Director of meeting date and time one week prior to meeting. 4. Quality Monitoring:A. DON will monitor Medical Director attendance at the monthly QI meetings.B. DON will conduct on-going monthly environmental/infection control rounds and monitor staff for appropriate infection control</p>		05/25/2011

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	<p>noted no physician attended the meetings.</p> <p>An interview with the DN (Director of Nursing) on 5/6/11 at 2:00 P.M. indicated the physician does not usually attend the quality assurance meetings. The DN indicated a physician does review the minutes of the meetings.</p> <p>In addition, interview with RN #7, on 05/05/11 at 2:45 P.M. indicated there had been no specific issues with infection control identified by the Quality Assurance team in the past year. She indicated the trending had identified no infections had developed while residents were residing on the long term care unit of the facility. She did indicate the whole acute and long term care facility had "worked on" hand hygiene as a whole and had implemented specific measures to improved compliance such as making the foam hand cleanser containers more easily assessable, having other departments watch for incorrect hand hygiene when entering and exiting rooms, and utilizing germinal wipes to clean equipment and hard surfaces and/or disposable equipment to prevent the spread of infections.</p> <p>3.1-52(a)(2)</p>				<p>practices. Results will be reported at the monthly QI Meeting. C. Revised environmental/infection control rounding form.D. Infection Control will continue to monitor and track the CCC infection rate monthly in order to maintain a <1% infection rate. If trends are identified, action plans will be put into place. Results will be reported during monthly QI Meeting.</p>		

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